NSCLC

National Senior Citizens Law Center

# Protecting the Rights of Low-Income Older Adults


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# Improving Delivery of the QMB Benefit

## Access issues from a beneficiary perspective

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*The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all.*

# Our Project

- Four technical issue briefs describing and providing recommendations on important issues facing dual eligibles:
  - Ensuring Consumer Protections in Integrated Models
  - Addressing “Bump-ups” in program rules and benefits
  - Building an integrated appeals system
  - Improving delivery of the QMB benefit

# Our Support

- Supported by a grant from The SCAN Foundation, dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.


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# Today's topic: Delivery of the QMB benefit

- The Goal of QMB: To make the full Medicare benefit available to low income beneficiaries who cannot afford premiums and copayments.
- The Reality: QMBs don't have needed access to Medicare providers and get billed when they shouldn't. Advocates report that problems getting to see specialists and mental health professionals are most acute.
- Why? Recommendations on fixes.
- Options for larger changes.

# Outline

- What is QMB
- Who are QMBs
- What doesn't work and recommendations
  - Provider payment amounts
  - Provider payment  processes
  - Balance billing
  - QMB identification
- Options for program redesign

# What is QMB

- Qualified Medicare Beneficiary program, a Medicaid benefit
- States required to include in their state plan
- Most comprehensive of 4 Medicare Savings Programs (QMB, SLMB, QI, QDWI)
- Created by 1988 Medicare Catastrophic Coverage Act
- Purpose: Make Medicare benefit accessible to low income beneficiaries
  - Medicare is a health insurance program that assumes ability to contribute through premiums and cost-sharing
  - QMB meant to let low-income people use their benefits by relieving them of financial participation responsibilities.

# What is QMB

- QMB Benefit:
  - Part B premiums
  - Part A premiums, if needed
  - Deductibles, cost sharing for Medicare-covered services
  - Protection against balance billing
  - No estate recovery
  - Not retroactive

# Qualifying as a QMB

- Minimum requirements- 100% FPL and same asset limits of as Medicare Part D Low Income Subsidy
  - Current FPL: $903/mo individual; $1,215/mo couple
  - Current asset limit: $6,680 individual; $10,020 for a couple
- States can set more generous limits
  - Nine states have no asset test. A few states have increased the income limit
- States can use different income counting methodologies

# Who are QMBs?

- Anyone meeting QMB definition, even if otherwise eligible for Medicaid.
- QMB-plus: People who qualify as QMB and also qualify for full-scope Medicare.
- QMB-only: People who qualify only as QMB but are not full benefit dual eligibles. "Partial duals."
- Note: Some full benefit dual eligibles are NOT QMBs. Usually medically needy. Income too high to qualify as QMB.

# Who are QMBs?

QMB Numbers—Rough estimates. Good data not available

- 8.9 million duals, including full and partial
- 6.9 million are full duals
  - About half are medically needy
  - About half are QMB
- About 2 million partial duals (QMB, SLMB, QI, QWDI)
  - About 600,000 partial duals are QMB
  - Chronic under-enrollment

*Most QMBs are full duals.*

*About half of full duals are QMBs*

# What's wrong: Low or no copayments for QMBs

- What should happen: state covers cost sharing
- The problem: providers usually get little or no payment above Medicare amount
- Result: inadequate access to Medicare providers
- Why:  BBA allows states to limit copayments to Medicaid amounts.  Most do.

# Low or no copayments for QMBs: Example

CA: New patient outpatient office visit, code 99205

| | |
|---|---|
| Medicare allows: | $225.45 |
| Medicare pays: | $180.36 (80%) |
| Medicaid allows | $82.70 |
| Medicaid pays nothing. | |
| Provider payment gap: | $45.09 |

# Partial remedies available

- Primary care – ACA provision
  - In 2013 and 2014, Medicaid must pay Medicare rates for primary care from primary care physicians
  - Limited timeframe, no coverage of specialists
  - Will increase access

# Partial remedies available

- Medicare Bad Debt Recovery Process
  - Available to Part A providers
  - All uncollectible debt. Incomplete payment by Medicaid for a QMB deemed an “uncollectible” debt
  - Medicare pays 70 percent
- Limitations
  - Only Part A, incomplete payment
  - Complicated process-Provider Reimbursement Review Board
  - HHS OIG wants program eliminated or reduced

# Recommendations

1. Require that QMB reimbursement rates should equal the full authorized Medicare amount for all Medicare covered services.
   - Increased FMAP likely required
2. Target provider and service categories where access is most difficult and pay full Medicare rates to improve access
   - Builds on ACA primary care provisions
   - Would require good analysis of current access problems
   - Access issues vary by state and regions within states
3. Require across-the-board increases to a percent of Medicare rates that is less than 100%
   - More efficient and comprehensive than current bad debt recovery program
   - Link to access improvement is speculative

# What's Wrong: Provider Payment Procedures

- What should happen: any Medicare provider can get QMB cost sharing payments without enrolling in Medicaid.
  - CMS guidance-submission of charges is enough
- The problem:
  - States require Medicaid application or a QMB application that is almost as complex
  - State Medicaid systems routinely bounce claims from non-Medicaid providers
  - QMB-only claims do not get forwarded from Medicare to Medicaid
- The result: Medicare providers don't get paid and don't want QMB patients. QMBs lose access to providers they need.

# Recommendations

- Simple payment submission procedures
- CMS provides states with best practices
- States publicize procedures on Web sites
- CMS and states improve coordination so all QMB claims are automatically forwarded to state for processing.

# What's wrong: Balance Billing

- What should happen: QMBs protected from any cost sharing responsibility for Medicare services
  - Explicit statutory prohibition
  - Providers cannot take QMBs as "private pay"
- The problem
  - Neither states nor CMS enforce
  - Some providers are unaware of prohibition
  - Outdated State Medicaid Manual provisions
- Result: QMBs get bills, collection action, co-pays collected in provider office.

# Recommendations

- More provider education
  - Recent CMS  notice is good start
  - States should do more too
- Enforce balance billing prohibitions
  - Statute provides that all Medicare and Medicaid sanctions are available
- Update State Medicaid Manual

# What's Wrong: Identifying QMBs

- How it should work:
  - Both providers and QMBs understand QMB benefit and how to use it
- Problem:
  - ID cards do not identify QMBs
  - Providers don't know and can't find billing rules
- Result:
  - QMBs get treated as if Medicaid-only
  - All problems previously identified

# Recommendations

- ID cards that clearly show QMB status
  - Balance billing prohibition
  - Phone # and Web site for providers
- Clear info for providers and QMBs

# Redesigning the QMB program

- Current structure is awkward.
  - State-operated Medicaid program to improve access to the federal Medicare benefit.
  - Structure requires state Medicaid programs to deal with providers who otherwise are not enrolled in the Medicaid system, leading to confusion for all involved.
  - Providers, especially those using the bad debt recovery process, bouncing back and forth between agencies, wasting resources and increasing chances for error.
  - Despite the resources expended, beneficiaries receive much less from the program than they are entitled to.

# Options

- State continues to operate QMB program
  - Full coverage of Medicare cost sharing
  - Federal financial participation
  - Improvements discussed above
- Impact
  - Improved access to Medicare providers
  - No additional administrative efficiencies
  - Doesn't require major restructuring

# Options

- State/federal hybrid
  - State pays Part A and B premiums
  - Medicare pays providers full Medicare rate
- Impact
  - Relieves states of some but not all financial responsibility
  - Streamlines provider payment
  - Potential program cost savings from simpler process

# Options

- Federalize the QMB program
  - Medicare absorbs Part A and B premium costs
  - Medicare pays providers 100% of Medicare approved amounts
- Impact
  - Disadvantages beneficiaries in states with more generous QMB eligibility standards
  - Seamless for beneficiaries and providers
  - Maximum efficiency and potential administrative savings

# Redesign Issues

- Allocation of financial responsibility
  - "Clawback" contributions from states?
  - Feasibility of increased federal contribution
- Enrollment criteria
  - Room for state variability?
- Enrollment, recertification and appeal responsibility
  - SSA  or state Medicaid or both
  - But need to ensure full Medicaid
  - SSA brings simplicity, potential to capture more eligible beneficiaries
  - Need for "no wrong door" procedures
  - Limits on SSA capacity; Inadequate of SSA appeals system

# QMB and integrated models

- Integrated models propose ‘best of both worlds’ for duals
- Won’t be realized without robust provider networks. Need QMB fixes
- Managed care models must be based on Medicare payments
- Shared savings in fee for service models can incentivize states to pay a larger amount of Medicare cost sharing.

# Conclusion

- QMB program is meant to give low income dual eligibles full access to the Medicare benefit
- The program largely fails to deliver on its promise.
- Addressing QMB deficiencies is a key element in improving the interaction of Medicare and Medicaid for low income people who qualify for both programs.
- Payment reform and administrative changes are necessary.
- Broader restructuring with protections in place should be explored


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